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FROM THE CHAIR OF THE BOARD OF CHANCELLORS

By Paul H. Ellenbogen, MD, FACR, Chair

Maybe I am giving a wee bit too much drama and importance to the recent creation of another website. But it is a step forward for our profession. RadiologyCentral.org comes to you from the ACR and the Intersociety Committee (ISC). The first ISC of the Board of Chancellors was established in 1936. The first summit meeting was held in the summer of 1979 and produced the following mission statement, which was created and later adopted by the committee members:

To establish and promote communication among the leaders of national radiological societies and to provide them with the open access to all the resources of the College through the committee, with the chair serving as an ombudsman for all radiologic organizations; to act as a catalyst between the Summer Conference and the College in its function as the lead agency for the radiologic community and particularly in consideration of those topics identified by the Summer Conference attendees which extend beyond the perimeters of any one society, including the College.

The following year, in 1980, the Intersociety Commission was formed, and a letter of invitation was sent to all identifiable national radiological societies. Twenty-two societies joined at that time. In 1996, the summit was renamed the Summer Conference. In 2001, the Intersociety Commission once again became the Intersociety Committee. Currently, more than 50 organizations participate, including two certifying boards.

So, what is RadiologyCentral.org? It is a tangible result of the deliberations of the Intersociety Committee in 2010 and 2011.

In 2010, the topic for the Summer Conference, held in Santa Fe, N.M., was “The Radiology Conglomerate: Optimizing the Structure and Function of the 50+ Radiology Organizations.” In 2011, at the 33rd conference of the ISC, the discussion continued in Sundance, Utah, under the title “Optimizing the Structure and Function of the 50+ Organizations, Part 2: A Unified Strategic Plan.” The summary of those two meetings can be found in the JACR.1

The member organizations of the ISC agreed that radiology would benefit from consolidation and collaboration of the organizations. The plan called for coordination of annual meetings, online educational materials, research infrastructure, and other aspects. The possibility of combining foundations was also brought up. The plan also suggested creation of a formal communication network.

At the ISC meeting in 2011, it was revealed that the 50+ organizations collectively hold 36 annual meetings, 53 percent of which are held in the spring. It was expressed that substantial benefit could be derived from coordinating meetings as well as educational materials. The opportunity for coordinated meetings would include dates and locations.

Thus RadiologyCentral.org was created to answer this need. As ACR BOC chair, I asked that the ISC in conjunction with the IT staff at the College move forward. Thanks to the efforts of many people, including Gerald “Chip” Dodd III, MD, FACR, chair of the ISC, and ACR staff members Pam Mechler, senior director of association-meetings services, and Michael Tilkin, chief information officer, RadiologyCentral.org went live in January 2013.

So, what does RadiologyCentral.org do? The home page takes you to the ISC mission statement and leads to a history of the ISC, which I have largely borrowed for the preceding paragraphs of this column.

Other points of interest on RadiologyCentral.org include the Societies link and the Calendar of Events link. The Societies link takes you to an alphabetical listing of our 50+ member organizations with their names, logos, and addresses. Click on any of these societies and you are taken to a page dedicated to that society’s listing, which includes its mission statement, executive director, officers, and contact info. Click on their link and you will be taken to the society’s home page.

Now for the best part: from the home page of RadiologyCentral.org, click on Calendar of Events. This will give you a chronological listing of all upcoming meetings and events that have been submitted to RadiologyCentral.org via the ACR. Click on any meeting and you will arrive on a page that gives a short description of the meeting along with the date, location, and a link to the website for that meeting.

In the upper right-hand corner of the Calendar of Events page, you will see Calendar View. One click takes you to an actual calendar with a monthly display of all society events and meetings, which can help you decide at a glance which meetings you want to attend. If you are planning a meeting, you can see immediately which dates are open and who else might be planning a meeting at that same time or in close proximity.

You can see all societies or filter by society, subspecialty/modality, and/or location (by state or Canadian province).

Of course, the information is only as good as that which is received by ACR. It is up to the intersociety member organizations to provide us with their logo, mission statement, leadership contact information, website link, and calendar of meetings. Please go online and check it out. //

ENDNOTE


RadiologyCentral.org, A First Step

“Houston. Tranquility Base here. The Eagle has landed…One small step for a man, one giant leap for mankind.”

— Neil Armstrong (upon landing on the moon on July 20, 1969, and then stepping out onto the lunar surface the following day)
ANNOUNCING THE FIRST-EVER DICOE™ AWARDS

At the AMCLC, the ACR presented the first awards under the new ACR Diagnostic Imaging Center of Excellence™ (DICOE™) program, which recognizes teams for outstanding efficiency, safety, and patient care. The DICOE program goes beyond accreditation to commend best-quality imaging practices and diagnostic care with a comprehensive assessment of the entire medical imaging enterprise, including structure and outcomes.

“The DICOE award reflects excellence at multiple levels — the professional staff, the technology, and the policies and procedures the organization follows — but, ultimately, it represents superior patient care,” says Debra L. Monticciolo, MD, FACR, chair of the Commission on Quality and Safety.

The first two awards were presented to the Hackensack University Medical Center in Bergen County, N.J., and the Mount Desert Island Hospital in Bar Harbor, Maine, two sites that participated during the program’s development. To find out how your practice or department can apply, visit www.acr.org/Quality-Safety/DICOE.

ABR OFFERS FOCUSED PRACTICE RECOGNITION IN CARDIAC CT

In 2012, the ABR implemented a pilot program for Focused Practice Recognition in Cardiac CT. The program is designed to allow ABR diagnostic radiology diplomates who are enrolled in maintenance of certification (MOC), meeting MOC requirements, and active in cardiac CT practice to achieve an added credential that demonstrates their commitment to maintaining quality, safety, and expertise.

“ABR diplomates who participate are the only physicians who can receive such recognition,” explains ABR executive director Gary J. Becker, MD, FACR. “This credential is an enormous opportunity and will be very valuable.” To find out more, visit www.theabr.org/FP-cardiac. To find out about the ACR Cardiac CT Certificate of Advanced Proficiency (CCT CoAP) Exam, which qualifies as a gateway to the Focused Practice Recognition in Cardiac CT, visit http://bit.ly/CCTCoAp.

UPDATE YOUR PRACTICE PROFILE FOR A CHANCE TO WIN!

To better serve our members and the specialty, the College created the Practice of Radiology Environment Database (PRED®), a web-based program designed to gather demographic information on the practice environments of radiologists, radiation oncologists, and medical physicists. Along with demographic information, PRED collects information on the sites each practice services and their physician roster. The information obtained through PRED is used by the College to improve service to its members, while at the same time making the ACR a stronger advocate for the interests of the radiology community. By keeping your practice information up to date, you help to improve the ACR’s service and products.

Update your practice profile before September 30 at http://pred.acr.org for a chance to win a Garmin Portable Navigation Device. If you have any questions regarding PRED or need login assistance, please contact the ACR Membership Department at 1-800-347-7748 or pred@acr.org.
The 2013–2014 College Nominating Committee (CNC) will recommend candidates to fill the offices of president and vice-president of the Board of Chancellors (BOC); elected positions on the BOC, the Council Steering Committee (CSC), and the CNC; and two member-in-training representatives to the Intersociety Conference (ISC). Additionally, the CNC will select a private-practice representative to attend the 2014 and 2015 ISC meetings. Any ACR member may submit recommendations for elected or selected positions to the CNC in care of the ACR Governance Office on or before December 31, 2013.

Each candidate must provide a current curriculum vitae, a recent black-and-white photograph, at least two letters of support from ACR members, and a completed Candidate Information Form describing the nature of their practice and their position on issues important to the College (available at http://bit.ly/CandidateForm). The information is reviewed by the CNC and published in the ACR Election Manual. Additional nomination information is available at http://bit.ly/NominationsACR or through the ACR Governance Office. All information can be sent to Kathy Bentley via email (kbentley@acr.org) or to the ACR headquarters at 1891 Preston White Drive, Reston, VA 20191. Candidates in contested elections must be present to deliver a short speech at the 2014 ACR Annual Meeting and Chapter Leadership Conference.

**BOC Elected Positions**

For 2014, three elected vacancies will be open for chairs of the Commissions on Body Imaging, Ultrasound, and Clinical Research and Information Technology. In addition, the chairs of the Commissions on Nuclear Medicine and Human Resources are each eligible for a second three-year term. One board member is also eligible for a second three-year term on the BOC. Candidates for the BOC positions should be qualified radiologists who have been actively involved in the College and have leadership qualities beneficial in addressing the issues brought to the BOC.

**Council Steering Committee**

For 2014, five or more eligible candidates, who must have at least one year remaining as councilors for the terms for which they are nominated, will run for four positions on the CSC, each for a two-year term. A candidate with only one year remaining as a councilor who wins election or re-election will serve the final year as a councilor-at-large. No member may serve more than six consecutive years on the CSC without a lapse of at least one year.

**College Nominating Committee**

For 2014, five or more eligible councilors or alternate councilors, who must be councilors or alternate councilors through May 2016, will run for three elected positions on the CNC, each for a two-year term. Members elected to the CNC by the council cannot simultaneously serve on the CSC.

**Members-in-Training**

Chapters are asked to submit to the CNC the names of interested, involved members-in-training to attend the ISC in 2014. The committee will nominate no more than four members-in-training, two of whom will be elected by the council.

**Private-Practice Representative**

The committee will select a physician who has a private office that is not affiliated with a hospital practice or who practices in a hospital without radiology residents. This representative will participate in the 2014 and 2015 ISCs.

**Society Representative**

The American Roentgen Ray Society (ARRS) will be asked to present three members of the ACR to represent ARRS for a three-year term on the BOC. After consulting with the BOC chair, the CNC may select one individual from ARRS. The American Radium Society (ARS) may also present three members of the ACR to represent the society for a three-year term on the BOC; however, the present representative of the ARS is eligible to serve a second three-year term.

HOW DID YOU CELEBRATE PET WEEK?

The ACR Marketing Department had a bit of fun spreading the word about a series of live webinars on PET/CT. The department sent out a call on Facebook asking for submissions for the official mascot for PET Week. And the winner was Mazel the cat, whose owner Howard L. Kahen, MD, says, “I was very impressed that as a kitten, Mazel could progress so quickly from plain film to cross sectional imaging interpretation. I am, however, quite surprised that he won’t read on a PACS. Personally, I think he hates the mouse.”
ACR ACHIEVES HIGHEST CME ACCREDITATION STATUS

The ACR has been awarded Accreditation with Commendation for six years as a provider of CME. The Accreditation Council for Continuing Medical Education awards this designation to less than 25 percent of accredited providers. “This achievement is a testament to the medical community that the ACR is dedicated to providing radiologists with valuable CME opportunities that promote change and quality improvement. ACR staff and the ACR Commission on Education have done exemplary work. We are extremely proud of this achievement,” said Cheri L. Canon, MD, FACR, chair of the ACR Commission on Education.

RUTHERFORDS REUNITED

For the last 20 years the J.T. Rutherford Fellowship has given radiology residents direct personal exposure to the ACR’s government relations activities and experience with state and federal legislative and regulatory processes. The fellowship is designed to inform residents about the governmental factors that influence and shape the future of radiology. Since the program’s inception in 1993, the government relations team has hosted more than 97 residents.

To celebrate 20 years of excellence and advocacy, a reception for all past and current Rutherford Fellows will be hosted at this year’s RSNA. For more information, visit www.acr.org/Advocacy/Rutherford-Fellowship.

SEEN AND HEARD

Scan the code to access the digital version and check out intriguing links from around the Web.

- Sports Concussions Aren’t Limited to Football Players
- What’s Lurking on Your Workstation?
- Medical Writing With Soul

IMAGING 3.0™ IN ACTION

Radiologists throughout the country are going the extra mile for their patients and exemplifying what it means to practice Imaging 3.0™. A recent post on the TEDMED blog brings Imaging 3.0 to life and shows the effect on a patient when her radiologist creates an environment of engagement, understanding, and empathy. Read the story at http://bit.ly/ExaminedLives.

SPR HONORS

The Society for Pediatric Radiology awarded its gold medal to Stuart A. Royal, MD, FACR, at its May meeting in San Antonio, Texas. Royal serves as radiologist-in-chief at Children’s of Alabama Medical Center and holds the Henry M. Burns Endowed Chair of Radiology position at the University of Alabama, at Birmingham. The former SPR president and former chair of the board of directors was honored for many years of service to the profession and to the society, but most noted were his years of fundraising and the efforts he spearheaded to move the society’s administrative management to the ACR in 2005.

Anupam Basu, MD (left), and Hui J. Chen, MD (right), were among the 2007 Rutherford Fellows.
AN UPDATE ON SPORTS CONCUSSIONS

In the November/December 2012 issue, the Bulletin explored the changing world of sports concussions (http://bit.ly/SportsConcussions). Now, emerging evidence sheds new light on the issue by using PET scans to detect chronic traumatic encephalopathy in living patients. To collect the data, researchers scanned the brains of five former NFL players. Concussion-related tau, a protein that can build up over time and ultimately kill brain cells, turned up in each player’s brain. Previously, this type of brain damage could only be seen in postmortem exams, limiting treatment and study. Researchers hope that by detecting the signs of concussion-related brain damage, physicians can better treat existing injuries and prevent further harm. Read more about the study in the February issue of the American Journal of Geriatric Psychiatry.

THE SPARK

Kick off discussion with these notes and quotes from the field.

“And don’t be afraid to talk to the patients. You might be one someday.”

“...Our medical colleagues, hospital administrators, and policymakers need to recognize us not just as docs in a black box spewing out reports, but as physicians who relate to our patients and referring doctors and participate actively in patient care.”
Back to School

WHILE MANY INDIVIDUALS HAVE FILLED THE PAST FEW MONTHS WITH SUMMER FUN, THE ACR HAS BEEN BUSY INNOVATING.

Who can forget that “back to school” feeling? Starting a new school year was always energizing for me, even if there was some regret that the lazy days of summer were over. At the ACR, this has hardly been a lazy summer. Between preparing our comments on the Medicare proposed rules and strategizing around the U.S. Preventative Services Task Force recommendations on lung cancer screening, the pace barely slowed. While many of our activities are repeat performances, our economics team has been at the forefront of a number of innovative efforts that I want to share with you.

With so much talk about payment reform in health care, a critical goal for your ACR Commission on Economics has been to understand how radiologists can survive and thrive in new payment models. We have an active Radiology Integrated Care Network that gathers information from members already participating in accountable care organizations and other integrated care-delivery systems. The leadership of this network has already published on radiologists’ experiences in these models and will continue to educate members as the models mature.1

We’re hearing a lot about how bundled payments will align incentives and reduce cost. The Centers for Medicare and Medicaid Innovation (CMMI) have awarded grants to 450 hospitals and post-acute providers to study how bundled payments work. As part of our effort to stay informed, we are actively soliciting feedback from radiologists within such institutions. To see if your institution is participating, check out http://bit.ly/InnovationMap. If your institution appears on the map, please contact us at econ@acr.org.

In addition to gathering information from the field, we are actively engaged in developing potential bundled-payment models that will recognize and reward the value of the imaging care provided by radiologists. I have participated in several efforts in the past to develop bundled or episode payments, and the hurdles are significant. Deciding on the distribution of payments and attributing both savings and costs can be complex. Often radiologists are not regarded as being central to the care-delivery process, a perception we are working hard to change through our Imaging 3.0™ initiative.

Recently we have been working collaboratively within the ACR, with the Neiman Health Policy Institute, and with other groups such as the Brookings Institute and the AMA to develop models that will both promote effective care and appropriately recognize the efforts of all members of the care-delivery team. Areas of initial investigation relevant to radiologists are breast cancer diagnosis, management of incidentally detected pulmonary nodules, and the initial evaluation of stroke. You’ll certainly also be hearing more about lung cancer screening in the near future; it represents an opportunity for radiologists to take the lead on an important public health initiative, just as we did for breast cancer screening. We aim to put radiologists right in the center of developing the program. Watch this space over the coming months for more details.

Our efforts are timely not just because of the CMMI bundled payment initiative. The Medicare Physician Fee Schedule and the Hospital Outpatient Prospective Payment System represent the payment world in which we all currently exist — and even these are changing. With language in the Proposed Rules for 2014 that seeks to equalize payments across various settings and discusses the development of bundled payments around surgical and other procedures, it is wise for us to take the initiative on making sure radiologists’ contributions are adequately reimbursed.

Another exciting effort has been our pursuit of a CMMI Innovation Award to study and promote the use of appropriate imaging through education of and consultation with referring providers and greater engagement with patients. Decision support using the ACR’s Appropriateness Criteria® represents the cornerstone of our efforts to highlight the value that radiologists deliver. We have been working closely with partners, such as the Altarum Institute, to demonstrate the benefits of the appropriateness criteria. Altarum received an $8.4 million grant in 2012 to work on reducing unnecessary imaging within a primary care network in Michigan using the ACR Appropriateness Criteria. When CMMI announced a second round of funding this summer, we at the ACR saw an opportunity to build on this important work. Pulling together partners from across the country and crafting the application and the payment model required to qualify for funding was an example of the ACR’s economics team doing what it does best: representing members’ commitment to the highest-quality patient care and advocating for payment models that support that commitment. Awards will be announced early next year.

All the efforts outlined above take place within an overall strategy that

(continued on page 29)
NOW THAT THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IS LAW, RADIOLOGISTS TRY TO DETERMINE WHERE THEY FIT INTO ACCOUNTABLE CARE ORGANIZATIONS.
It’s a maxim heard often these days: the health-care industry is transforming from a volume-based business into one predicated on delivering high-quality patient care. With the Supreme Court’s decision to uphold the Patient Protection and Affordable Care Act (PPACA), and with President Obama’s re-election last year, the act has become the law of the land. One important part of the legislation involves the creation of institutions called accountable care organizations (ACOs). These entities are made up of doctors who coordinate care for at least 5,000 Medicare beneficiaries in order to streamline services and save the industry money. The physicians are then rewarded for these financial savings by sharing in them. But where do radiologists fit in?

The Central Node

Although the concept of shared savings in health care has existed for a long time, ACOs are only now in their infancy. HHS provided the framework for the adoption of ACOs in section 3022 of the PPACA in 2011, authorizing CMS to allow ACOs to contract with Medicare the following year. Since then, many physicians — including radiologists — have organized themselves into ACOs with the intention of raising the level of patient care while trying to rein in health-care expenditures. Since the law’s inception, over 250 ACOs have come into existence.

With heavy emphasis placed on coordination of care, Jack M. Farinhas, MD, interventional neuroradiologist and associate professor at Montefiore Medical Center in New York City, notes that radiologists should see themselves as essential members of an ACO. “The radiologist is the central node to many clinical arms,” he explains. For example, at Montefiore, he often reviews the exact same studies with neurologists, neurosurgeons, and other medical teams. “Being in a central position, we can offer our expertise in a way that helps to coordinate communication among different groups within an ACO,” he asserts.

Despite the fact that some radiologists see themselves as central to the success of ACOs, many radiologists perceive themselves inaccurately, says David A. Rosman, MD, MBA, medical director at Massachusetts General Imaging Worcester and associate director of business development at Massachusetts General Imaging at Massachusetts General Hospital. “We’ve been a target for reimbursement cuts from Congress. But the governing bodies of ACOs haven’t targeted us in the same way. These groups are focusing on managing chronic diseases in an attempt to reduce the long-term costs associated with those diseases. Individual episodes like imaging do not cost as much as expenditures on chronic diseases like diabetes or coronary artery disease as a whole and thus are lower on their priority list.” It’s critical for radiologists to get involved now in the leadership structures and decision-making processes of ACOs, he says, before imaging becomes a target.

A recent article co-authored by Rosman, Farinhas, Christopher G. Ullrich, MD, FACR, and Geraldine B. McGinty, MD, MBA, FACR, noted, “The initial focus of ACOs has not been on decreasing imaging but rather has revolved around preventing readmissions and reducing lengths of stay.” Since these are areas in which imaging often does not play a significant role, the authors assert, this dynamic has prompted many radiologists to sit back and watch how things play out. Adopting a wait-and-see approach will not, however, empower radiologists. “If we only get involved once we’re targets, then it looks like we’re only interested in participating in order to cover ourselves. Our input will be much more credible if we act now as part of the team,” argues Rosman.

Tools for Success

If radiologists wish to assert themselves into the process of helping to coordinate care and also influence how they will be paid through their ACO, the time to do so is now. Fortunately, there are strategies in place that can help doctors through this transition process. Two of the most significant of these strategies involve becoming a “good citizen” within the ACO and making the case for the adoption of clinical decision support software.

In a recent article on how radiologists can become good citizens within the medical community, authors Lee, Herrington, Donner, and Bluth emphasized the need to become part of medical boards and committees at the hospitals with whom they contract. They write, “In multidisciplinary institutions, radiologists serving on boards and hospital committees can advocate on behalf of their practices and help shape the institutional policies and practices with regard to medical imaging.” This idea is in line with how doctors can ensure that their voices are heard within ACOs. “You’ve got to get out there and build stronger relationships with your colleagues,” says McGinty, chair of ACR’s Commission on Economics. “You’ve got to be active in your state medical society, not just your state radiologic society. It’s all about being visible, and that way people will better understand your value.”

In addition to becoming an active member of the medical community, radiologists can demonstrate their value to ACOs by promoting the use of clinical decision support software. ACR’s clinical decision support technology, called ACR Select™ (www.acrselect.org), is the web service version of ACR Appropriateness Criteria® (AC). The software provides referring physicians with a tool for ensuring that they order the most appropriate study every time, allowing radiologists to assume a new role: that of peer-to-peer consultant. As a consultant, the radiologist can help...
guide the referring physician during complex encounters in which the AC do not provide clear guidance, or when a referring physician wishes to override criteria for compelling clinical reasons. This will help the ACO hold down imaging costs and will contribute to shared savings. According to Farinhas, although some radiologists worry they’ll be displaced by software, these fears are premature. “There will always be a place for radiologist expertise in complex clinical scenarios, but we need to be proactive here and offer our expertise in a human way. We cannot allow our expertise to be automated by computer software. This is our opportunity to manage utilization while securing our place in the center.”

Assuming an expanded role as not only an imaging expert but also a consultant can potentially open a new revenue stream for radiologists, who have seen their Medicare reimbursements fall year after year. However, figuring out how to be fairly compensated as a consultant within the ACO framework presents a challenge. “It’s been difficult for radiologists to develop what I would call the ‘arithmetic’ of how we are valued within an ACO,” explains Ullrich, a private practice neuroradiologist at Charlotte Radiology PA in Charlotte, NC, and chair of the ACR Utilization Management Committee. “There is no formula we can point to today to say, for instance, ‘Radiologists deserve eight percent of the cash flow.’ In reality, what occurs in virtually all of these organizations is that you’re actually paid on a fee-for-service basis coupled with some type of utilization management strategy,” Ullrich says that the ACR and RBMA are both actively examining valuation metrics to assist members in their local negotiations.

**Multiple Channels of Income**

Although many different ACO payment models provide radiologists with shared savings opportunities, McGinty agrees that, at least for the foreseeable future, most of them will continue to incorporate some form of fee-for-service. “Radiologists will likely get paid at the time of service on a fee-for-service basis,” she notes. “Then a percentage of the savings that they share in will come at the end of the year and the goal is to participate in the distribution of the savings.”

She highlights examples of patient scenarios that reflect how radiologists in ACOs might be paid in a hybrid fee-for-service and shared savings model:

If my group is part of an ACO, a portion of our patients, though by no means all, will be Medicare patients that are in the ACO’s shared savings model. We’re committing to giving those patients high value care for the year and also delivering that care at a lower cost. My group will get paid to deliver the service on some kind of discounted fee-for-service basis, but at the end of the year, if there are savings, our ACO will get some money back, so we will negotiate to share in the distribution of those savings. Our ACO may also have negotiated a bundled payment with commercial payers for procedures such as hip replacements, and the radiologists in my group will share in that payment based on a negotiation that recognizes the cost and value of the imaging care we deliver. Our group will likely also still see fee-for-service patients who are not in the shared savings model and are not part of any bundled payment plan, although I expect the relative numbers of those patients to decline over time.

McGinty asserts that although most of the shared savings models hold the possibility for all of the doctors at a given ACO to benefit from these savings, radiologists need to be on the alert for payment models that are high risk. Among the most potentially troublesome models are those that incorporate capitation, according to McGinty. “When considering a capitation agreement you need to have a very good understanding of the cost and level of care you’ve historically provided to the patient population for which you are about to assume risk. Otherwise you may find yourself floundering as many did in the old managed care days,” she says. “You’ve also got to have some ability to manage imaging utilization within the population for which you are at risk. With good planning, a capitated arrangement can allow a stable income stream and align incentives, but you’ve got to go into it with your eyes open.”

Whether they lobby to be paid through capitation or another model, radiologists working with ACOs would be wise to make their voices heard now. Radiologists can demonstrate their value to these organizations in a multitude of ways, including joining a hospital committee or meeting with hospital administrators to discuss the implementation of ACR Select software. Despite the tectonic changes transforming medicine, becoming involved in a shared savings or integrated payment model such as an ACO can offer an opportunity for radiologists to reassert their central role in quality patient care. //

To get involved in the Radiology Integrated Care Network, which was developed to bring together radiologists who are endeavoring to work in new payment models, contact Pam Kassing at pkassing@acr.org.

ENDNOTES

Things are changing in the world of health care. And as the health system shifts, so does the business climate. When it comes to marketing, a growing number of practices are responding to the changes by trying new things and focusing on the needs of their patients more than ever before. The Bulletin spoke with three innovative practices (each of whom went home with one of RBMA’s Quest Awards this year) that are changing their paradigms to help their practices thrive.
Charlotte Radiology
Charlotte, N.C.

Charlotte Radiology knew it needed to change something about its marketing of uterine fibroid embolization (UFE) procedures. There was no shortage of women affected by the condition, and Charlotte Radiology offered a minimally invasive procedure that could greatly benefit patients. For years, the practice had marketed the procedure to referring physicians, but its referring volume remained flat.

The Solution
Mary Margaret Williford, vascular and interventional marketing manager, convened a focus group composed of African-American women, the demographic most likely to suffer from uterine fibroids, and set out to understand how women with fibroids go about seeking treatment and what they value in a health-care provider. “What we found was that they don’t really have a preference about their physician’s specialty; they just want their fibroids taken care of,” says Williford. The focus group uncovered significant patient confusion about treatment options, particularly interventional radiology procedures, like UFE. “There’s some confusion when it comes to what an interventional radiologist does,” says Eric A. Wang, MD, touching on the common misperception that an interventional radiologist can diagnose but not treat fibroids.

Charlotte Radiology decided to brand the procedure itself and leave the name of the practice out, since that seemed to be where some of the misunderstandings lay. It set up a separate phone line for UFE patients and launched a website dedicated to educating patients about fibroids and outlining treatment options.

It also began marketing directly to its targeted demographic. “In my opinion, mass marketing to all women is a waste of money when we can hone in on a specific group that is most affected by this condition,” says Williford. Charlotte Radiology relied on focus group data to formulate everything from the tone of the communications to the design of the website and marketing materials.

The Results
Since the inception of the UFE marketing campaign, more than 600 patients have reached out to Charlotte Radiology about UFE procedures. In the first half of 2013, more than 100 potential UFE candidates contacted the practice.

The Takeaway
Your marketing approach may need to address patient confusion about the role of radiology outside of diagnostic imaging. It may also benefit your practice to target certain segments of the population with your marketing.

Diagnostic Imaging Northwest
Bonney Lake and Puyallup, Wash.

The Challenge
Diagnostic Imaging Northwest wanted to help its patients stay current with their screening mammograms and keep up to date with screening recommendations. Many patients also associated the screening with discomfort, causing them to put off their mammograms.

The Solution
To increase screening rates in the community and boost its brand recognition, Diagnostic Imaging Northwest looked at how it could surround a sometimes unpleasant procedure with positive experiences, while continuing to educate women on the importance of early detection.

Marketing and communications manager Rachael Costner began planning...
free events to encourage screening and to help women build connections within the health-care community. One of her first projects was the Mammography Promise Tea Party, an event to celebrate women’s health. Her goal was modest: 40 attendees. And she reached it, paving the way for bigger events in the future, like teaming up with an area hospital system, MultiCare, to host a community breakfast for more than 800 5k participants, complete with radiologists in pink aprons serving pink pancakes.

One of the most successful events took place after months of buildup. Each patient who came in for a mammogram received a rose quartz stone with an invitation to a jewelry-making party. Costner emphasized to patients that rose quartz is traditionally known as the gemstone of love and is said to have calming powers. Patients brought their quartz to the party, where they had a chance to incorporate the stone into a piece of jewelry and connect with other patients. “People can share their stories and have fun,” says Costner. “If they want to talk about what’s going on with their health, they can. If they don’t want to, they don’t have to.”

Costner opens events to everyone interested, whether they are patients or not. In addition to the initial invitation, she gets the word out by leaving fliers in referring physicians’ offices, advertising on the practice website, including events on community calendars, and posting on social media.

**The Results**

Attendance at events has steadily increased, building goodwill while also boosting the practice’s visibility in the community.

**The Takeaway**

When increasing your practice’s community involvement, start small and let initiatives build momentum.

**Mountain Medical**

_Salt Lake City_

**The Challenge**

As the recession set in, a growing number of patients were forgoing imaging studies for financial reasons. “Our health-care community noted a decline in patient outcomes as patients were not following through with recommended imaging and treatment,” says Mary Christensen, director of marketing. “Patients were feeling frustrated because there wasn’t a clear way to find out how much their imaging study was going to cost.” Both Mountain Medical radiologists and their referring physicians were looking for ways to help patients save money and make informed decisions about their health care.

**The Solution**

In order to respond to their customers’ needs, Mountain Medical’s marketing team tried to put themselves in the shoes of the customers. “We tried calling facilities (even our own facility!) to get estimates,” says Christensen, “and we couldn’t get clear answers.”

Mountain Medical decided to remedy the situation by making their fees transparent. Staff set up a spreadsheet to calculate patients’ out-of-pocket costs and then gave out estimates for imaging up front. Paired with Mountain Medical physicians’ well-established reputation for quality, this feature became a key marketing point for the practice.

The marketing team went to referring physicians, explained the idea, and asked for their support in educating patients. This helped strengthen relationships between radiologists and referring physicians as they worked together to encourage patients to follow through on their imaging.

**The Results**

Before the campaign, less than 1 percent of patients reported choosing Mountain Medical because of price. After the first campaign, the figure went up to 17 percent. Now it’s hovering at about 23 percent.

**The Takeaway**

Cost savings are a powerful motivation for patients, particularly in the current economic climate.
Traditionally when patients need imaging services, they visit their local hospital or outpatient imaging center. But for people living far from the nearest hospital or imaging clinic, for those with difficulty getting around due to health issues or other circumstances, and for patients who simply have trouble fitting a trip to a clinic into their schedule, mobile imaging is an alternative that can provide the care they need at a convenient location — and it’s a service that many expect to grow as technology continues to advance.

MOBILE IMAGING UNITS ARE CONVENIENT FOR PATIENTS, BUT ADDING ONE TO AN EXISTING PRACTICE IS NOT A DECISION THAT SHOULD BE MADE LIGHTLY.

By Jenny Jones
Several types of mobile imaging programs exist today. Some provide specific screenings such as mammograms that patients may not have access to otherwise, while others offer a slate of services for homebound, nursing home, and incarcerated patients unable to visit a clinic. Hospitals and radiology practices operate mobile units as extensions of their businesses, while mobile imaging services companies are dedicated to mobile radiology exclusively. “Mobile imaging provides a convenience for the patient,” says Dean F. Berger, chief operating officer of Dynamic Mobile Imaging (DMI), a family-owned mobile imaging services company that offers digital X-rays, electrocardiograms, Holter monitoring, and ultrasound throughout Virginia, Washington, D.C., and parts of Maryland. “We can do everything with our equipment that can be done in a hospital.”

In addition to providing another avenue for patient care, mobile imaging can help attract new patients to an existing health-care system. But not every hospital or clinic is well positioned to operate such a program. Things that must be considered include the size of the existing practice, maintenance and upkeep costs for the vehicle and scanning equipment, staffing and scheduling, image transmittal, follow-up care for patients, and marketing. “You really have to look at whether you have the business to support a mobile unit on an ongoing basis and consider what it does for you in the long run,” says Anne E. Pileggi, administrative director of system imaging services for Trinity Mother Frances Hospitals and Clinics in Tyler, Texas, which has operated two mobile MRIs and a mobile mammography unit for approximately 10 years. “You have to really be careful because it’s an expensive proposition.”

Maintaining Quality of Care
Mobile imaging services companies usually operate out of mini vans. Their equipment is not fixed to the vans, so it can be taken into the facility where the scan is to be performed. In addition to serving nursing homes, prisons, and homebound patients, these providers often supplement rural health-care practices that cannot financially sustain radiology equipment and staff. The companies usually visit those practices on a regular schedule, setting up their equipment in a vacant room so patients don’t have to travel to the hospital or imaging center. “You might have a physician out there who sees 10 patients a day,” explains Deborah A. Berger, chief executive officer of DMI. “The cost of getting X-ray equipment is roughly $75,000 to $100,000 plus the cost of a full-time technologist; it makes no sense.”

Other types of units use equipment mounted within the vehicle, which patients board for their scans. Depending on the need, these vehicles can be cargo vans, recreational vehicles, or 18-wheelers. These
Mobile units are often set up in a way that is similar to a traditional office, with a small waiting area, changing room, and exam space. Women’s Center for Radiology in Orlando has operated a digital mobile mammography unit in central Florida for nearly three years. Arlyn S. Grant, the mobile unit coordinator, says patient comfort is a key to the success of the mobile unit. “When a woman walks in the door, there’s generally nobody else in the waiting area because of the way we schedule patients, so they’re not walking into a crowded space,” Grant explains. “We say, ‘Sit down on the sofa and kick up your feet.’” The goal, she says, is to make the experience as pleasing as possible so that the women return for their mammograms every year.

Most mobile imaging units are staffed by radiology technologists and, often, assistants who greet and register patients, schedule the unit, and, in some cases, drive the vehicle. Scans are typically performed with the same type of equipment and in the same manner as in a traditional office setting. The primary difference is that, because they are on the road, the technologists’ direct interaction with radiologists is limited. “The technologist on the mobile unit needs to be able to anticipate the needs of the radiologist,” Grant says. If the technologist has a question, she will call the radiologist for consultation.

Mobile units operated by hospitals and radiology clinics transmit their images from the unit to the practice’s radiologists, who then read the scans just as they do with those taken in the office. But most mobile imaging services companies contract with teleradiology groups to read their images. “The images are read by the radiologists and then, of course, we get the final reports back,” explains Dean Berger, whose company has a staff of registered and licensed radiology technologists. “We have it set up so that the ordering physicians also have ways of viewing the images and reports, just like a hospital PACS system.”

**Not a Moneymaker**

Maintaining and operating mobile units, particularly large ones with mounted scanners, can be costly because often the equipment is heavy, the gas mileage poor, and the driving time extensive. “These mobile units will never make money,” says Jennifer A. Harvey, MD, professor of radiology at the University of Virginia School of Medicine in Charlottesville, Va., which has operated a mobile mammography unit for the past 10 years. “If you’re driving four hours and then doing 30 mammograms, there’s no way that the reimbursement for those 30 mammograms is going to cover your costs.”

For this reason, many hospitals and clinics operate mobile units as a community service, not a revenue generator. This is particularly true for those with mobile mammography programs, whose goal is to make it convenient for women of the appropriate age to get preventive annual screenings. “Women are so busy between careers and families and all of their responsibilities that they put their own health last,” Grant says. “It’s important for us to get out there and get to these women. If we just sit and wait for them to come to us, they’re not coming.” Statistics show that breast cancer mortality has declined significantly in the past 15 years as a result of mammographic screening, Harvey notes. “But if women aren’t getting their mammograms, we can’t have much of an impact on their breast cancer mortality,” she says.

While mobile imaging is not without its challenges, many believe demand will only grow as the population ages and real-time data transmission improves. “In places like nursing homes, for instance, patients can’t move as easily, and we’re going to have to bring health care to them in different ways, whether it is mobile ultrasound, mobile X-ray, or other types of health care projected into these types of facilities,” says Arthur J. Greene, MD, president of Excalibur Healthcare, a telemedicine company headquartered in Maple Shade, New Jersey. “It’s there now, and it’s just going to grow.”

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A Teachable Moment

A RADIOLOGY RESIDENT VISITS THE ACR EDUCATION DEPARTMENT TO GROW AS AN EDUCATOR.

By Chris Hobson

During the winter of 2013, Lu Anne V. Dinglasan, MD, MHS, vascular and interventional radiology fellow at Brigham and Women’s Hospital in Boston, visited the ACR Education Department in Reston, Va., as this year’s Valerie P. Jackson (VPJ) Education Fellow. The Valerie P. Jackson Education Fellowship provides the opportunity for a radiology or radiation oncology resident, fellow, community or academic radiologist, radiation oncologist, medical physicist, or for an educator with a specific interest in the field to gain direct exposure to the operation of ACR’s Education Department. The primary goal of the fellowship is to acquaint fellows with development processes for a wide range of lifelong learning activities for residents and practitioners, including various aspects of compliance with the Accreditation Council for Continuing Medical Education accreditation criteria, and to enable fellows to advance their interests in education. As part of the fellowship, fellows are required to complete a project or activity pertaining to the delivery of educational materials and lifelong learning in radiology. The ACR Bulletin asked Dinglasan about her experience.

Why did you decide to apply for the VPJ Education Fellowship?

I applied for the fellowship because of my long-standing interest in education, especially at the medical student level, where I believe early radiology exposure is essential to piquing the interest of the best students to become future radiologists. In addition, I’m interested in radiology education at the international level, where, in resource-limited settings, it can make huge differences in helping primary-care clinicians and caregivers make diagnoses and formulate treatments.

What were your goals coming into your visit to the ACR headquarters?

My goals were threefold: to become more familiar with all the educational endeavors at the ACR, to explore the development of an educational tool from inception to practice, and to understand the educational collaborations between the ACR and practicing radiologists.

Do you have a mentor who encouraged you to apply for the fellowship?

Mary H. Scanlon, MD, FACR, my program director, and Judith Aronchick, MD, one of my chest attendings who is heavily involved with medical student education, were both instrumental in my decision to apply. Early on, they both recognized my interest in teaching and education, and both encouraged me and served as my advisors through all the education projects I have developed as a resident. These included revamping the radiology-anatomy correlates taught during the first-year medical student anatomy course, as well as developing a basic radiology curriculum I designed for non-radiology house staff in Kenya. Because of these positive experiences with Dr. Scanlon and Dr. Aronchick I believe they wanted me to further cultivate my passion and learn new ways to develop innovative and creative curricula for medical students, radiology residents, and non-radiologists abroad.

What were the highlights of your visit?

Highlights of my visit included meeting the e-learning development team and participating in a conference call with Ellen Brown, assistant director of ACR’s e-learning programs, and John S. Pellerito, MD, FACR, in which we talked about cutting edge ways to incorporate ultrasound into the pre-clinical curriculum in medical school; meeting Vinay Sandhir, senior director of the ACR Education Center, and learning about the development of the center; as well as meeting the Continuous Professional Improvement team and learning how they collaborate with radiologists.

What did you learn during your fellowship that you will apply in the future as an educator?

I definitely want to use aspects of the interactive program used in the ACR Education Center to develop a more interactive program to simulate what it’s really like to be a radiologist for senior medical students considering a career in radiology. In addition, I’d like to incorporate the ACR Appropriateness Criteria® into the curricula for non-radiology clinicians so that they can understand which diagnostic tests to use, especially in a resource-limited setting.

What project will you undertake that will apply the knowledge you learned during your fellowship?

I’d like to continue making the medical student radiology elective at the University of Pennsylvania more interactive by using ideas from the ACR Education Center, and I’d like to incorporate the ACR Appropriateness Criteria in the radiology curriculum I developed for resource-limited third-world settings. //

For more information please visit http://bit.ly/VPJFellow, or contact Carrie Smith in the ACR Education Department at (800) 227-5463 ext. 4579.
Health-care expenditures in the United States increased tenfold between 1980 and 2010 and continue to rise. As a result, states across the nation are seeking solutions for controlling health-care costs without compromising care. While many states are turning to managed care companies and accountable care organizations, Arkansas has embarked on a different approach that offers financial incentives to individual health-care providers to deliver more efficient care. The Health Care Payment Improvement Initiative is a collaboration between Medicaid, the Arkansas Department of Human Services, and two of the state’s largest private insurers — Arkansas Blue Cross and Blue Shield and Arkansas QualChoice. Introduced by Governor Mike Beebe in 2011 and launched in late 2012, the initiative is designed to reduce health-care costs while ensuring patients receive premium care, says Dawn Zekis, director of health-care innovation for the Arkansas Department of Human Services. “When it comes to Arkansas, we knew the things we didn’t want to do in terms of having to reduce rates, cut benefits, or do things that would cause us to get between the patient and the provider,” she says. “We saw the payment improvement initiative as the best path forward to increase efficiency, bend the cost curve, and increase the overall quality in the system.”

The initiative creates an incentive for health-care providers to manage costs and quality. Those providers who do not exceed a predetermined cost threshold as established by each payer and who meet quality metrics developed in coordination with stakeholders — including providers, patients, advocates, policymakers, and caregivers — will receive a share of the savings (an incentive). Those who go over the threshold or fail to meet the quality metrics must cover a portion of the excess costs (a penalty). The approach is expected to have a significant impact on how care is managed. One likely result will be increased data sharing as referring physicians seek consultation from radiologists and other specialists to ensure they order appropriate tests at appropriate times. James E. McDonald, MD, vice chair in the Department of Radiology and director of the Division of Nuclear Medicine at the University of Arkansas, thinks this consultative approach will highlight and enhance the value of radiology. “The opportunity for radiology is significant in this system, because we can distinguish ourselves by the quality of service and particularly by the quality of advice we provide.” — James E. McDonald, MD

**Multi-Pronged Approach**

The payment improvement initiative has two main components. The first focuses on conditions, known as episodes of care, that should be treated within a given length of time. The payers — Medicaid and the private insurers — have established five common episodes as a starting point: upper respiratory infection, perinatal care, attention deficit/hyperactivity disorder, congestive heart failure, and total hip and knee replacement. For each episode, the payers will designate a caregiver — often the diagnosing physician — to serve as the principal accountable provider (PAP), who will be responsible for managing the cost and quality for that episode. In the case of an upper respiratory infection, for instance, the PAP will most likely be the primary care physician, but could also be a surgeon or even an entire hospital, depending on the episode, Zekis says. “For example, if we’re working on a tonsillectomy episode, in that case the provider performing the procedure would be the PAP,” she explains. PAPs and all other health-care providers, including radiologists, will submit claims and receive payments, just as they have always done. The difference is that at the end of a predetermined performance period, typically a year, the payers will reconcile each PAP’s claims to determine eligibility for a financial incentive or penalty. In addition to examining costs, the payers will compare the care that was provided to established quality metrics to ensure the PAP didn’t skimp on services. If the PAP does not meet those quality metrics, even if costs were within the commendable range, he or she will be ineligible for the cost-savings incentive, explains David Wroten, executive vice president for the Arkansas Medical Society. “Between the
“Between the quality measures and the setting of the cost thresholds, they’ve done a pretty good job of removing any incentive to under treat or ration care.”

— David Wroten

quality measures and the setting of the cost thresholds, they’ve done a pretty good job of removing any incentive to under treat or ration care,” he says.

The other chief component of the initiative focuses on population-based health care through patient-centered medical homes and health homes. Under this concept, providers will have incentives to address a patient’s overall health needs, with emphasis on preventative care and chronic conditions. In addition to financial incentives, providers will receive per-member, per-month payments to cover the costs of such things as coordinating care and providing consultations. This represents a significant change from the traditional fee-for-service model, which does not compensate providers for many of the services they provide outside of office visits, Wroten says. “Under the fee-for-service model, you only get paid for the services you actually deliver for which there’s a CPT code,” he says. “The fee-for-service model does not compensate physicians for the things that we need physicians to do in order to keep patients healthier, which in turn holds down health-care costs.”

Standing Out

In the past, most referring physicians had no idea how much imaging, lab tests, medications, and other care components cost. But this new initiative requires them to be more aware of such costs and more discriminant about the care they dispense. For instance, when patients presented with common upper respiratory infections under the old payment model, providers often issued prescriptions for antibiotics, even though the medications do not treat viruses. “Way too many antibiotics were being written for just normal, run-of-the-mill acute respiratory infections, and a lot of that is because of patient demand,” Wroten says. “Every parent who takes a sick kid to the doctor or emergency room wants an antibiotic, and the physicians have to start saying, ‘No, that’s not necessary.’” Now, physicians have an incentive to explain why antibiotics won’t work.

Physicians will also be prompted to give greater consideration to the tests they order and the specialists with whom they work. As a result, radiologists may find themselves in a more competitive position for referring physicians’ business. “For the first time, the referring physician can be financially rewarded for identifying the high-quality imaging provider and will be motivated to look to that provider for advice about the most cost-effective way to answer the clinical question,” McDonald says. “I see this as a tremendous opportunity for radiologists to distinguish themselves as true partners for referring physicians.”

One way McDonald envisions helping referring physicians manage costs is by incorporating ACR Select™ (www.acrselect.org) into the university’s Epic electronic medical record (EMR). Referring physicians can then access the system to retrieve information about different radiology tests, which will help them determine the best tests for specific conditions. From there, they could click on a link to view the imaging schedule and arrange appointments for their patients directly, McDonald says. “Now primary care physicians, motivated to make sure they order the right test, will have the evidence at their fingertips to make the right choice,” McDonald says. “With everybody going to an EMR and with ACR Select available as a plug-in solution, I think we will have the tools to educate our referring physicians to do a better job for the patient, in addition to lowering costs and reducing radiation exposure.”

ENDNOTE

Sharpening the Saw

THE ANNUAL EVENT OF THE RADIOLOGY LEADERSHIP INSTITUTE BRINGS TOGETHER RADIOLOGISTS TO INTERACT AND INSPIRE EACH OTHER — AND IMPROVE PATIENT CARE.

By Brett Hansen

More than a year has passed since the ACR announced the formation of the Radiology Leadership Institute. Since then, the institute has integrated a variety of webinars, lectures, and even MBA programs into its curriculum. Among its most notable offerings, however, is its annual event — a multi-day course featuring world-renowned faculty from the Kellogg School of Management at Northwestern University in Evanston, Ill., and prominent leaders within the radiology and medical communities.

Daschle Endorses ACR Efforts

Among the many highlights of the event, a keynote address was given at the RLI Leadership Luminary Award dinner by former Senate Majority Leader Tom Daschle — who was also one of the architects of the Affordable Care Act. Daschle endorsed ACR’s efforts, especially its utilization management policy initiative. "I can’t think of a better example of redesigning and improving [health care] than the ACR imaging utilization management policy initiative."

— Tom Daschle

Despite the uncertainty, Daschle posited that radiologists must examine their own resiliency, innovation, collaboration, engagement, and leadership. “We need motivators. We need risk takers,” he concluded.

At the dinner, the RLI Leadership Luminary Award was given to Daniel H. Johnson Jr., MD, FACP, and Alexander R. Margulis, MD, DSc, FACP. “Their exceptional experience and exemplary level of leadership in organized radiology is nothing short of inspirational,” expressed Cynthia S. Sherry, MD, FACR, medical director of the Radiology Leadership Institute and chair of the ACR Commission on Leadership and Practice Development.

Reputable Radiologists

In addition to Daschle’s keynote speech and the Kellogg faculty’s presentations, the radiology leaders themselves spoke during the event’s sessions. Radiology-specific lecturers included Alexander M. Norbash, MD, MHCM, FACP, Arl Van Moore Jr., MD, FACP, Lawrence R. Muroff, MD, FACP, Jonathan W. Berlin, MD, MBA, FACP, Ricardo C. Cury, MD, and Richard B. Gunderman, MD, PhD, FACP.

Norbash spoke on the topic of applied leadership. He noted an important distinction between the words “leadership” and “management.” “Managers are typically responsible for a defined unit within a larger organization that sets the goals,” he said. Leaders, on the other hand, set a direction, cope with change, motivate, inspire, and align people.

As practice leaders, radiologists will have the opportunity to become more involved with creating strategic alliances with their hospitals, explained Moore. The reason strategic alliances fail is because of a lack of confidence in each party’s goals and objectives. To overcome these difficulties, Moore suggested, engage the other party in strategic planning.

When creating strategic or other types of alliances with hospitals, Muroff added, a radiology practice must either be or appear to be united when negotiating and must have an alternative plan if negotiations break down. He also called upon practice leaders to utilize their sources of power — skills, relationships, service, and medical offices held — to negotiate the best terms possible.

Berlin continued the leadership discussion in his presentation, “The Importance of Understanding and Managing Group and Team Dynamics in Future Radiologic Practice.” In the days before PACS, he noted, radiologists and their colleagues had time to chat while film was drying. One byproduct of these interactions was team building. Now, however, digital imaging and PACS have pushed away much of the incidental down time associated with generating images, leaving radiologists to work alone and without routine breaks in workflow. To remedy this, Berlin stated, “We have to change our culture.” He then quoted Richard Duszak Jr., MD, FACP, saying, “A radiologist’s value lies not in a report, but in meaningful and actionable information that improves patient care.”

For more information about the RLI Annual Event or the RLI’s other course offerings, visit www.radiologyleaders.org. For more information about the Kellogg School of Management, visit www.kellogg.northwestern.edu.
Editor’s Note: ACR member James E. Heisel, MD, of Jackson Radiology Consultants in Jackson, Mich., responded to the June ACR Bulletin article “Adapting to Change” (http://bit.ly/Adapt2Change). The article sought to explain how, given the drastically shifting medical landscape, radiologists must adapt in order to thrive. Below we’ve printed some of Dr. Heisel’s most salient points, along with responses from the ACR’s Imaging 3.0™ Work Group.

Dr. Heisel: The article proposes that radiology will trend toward having little or no value in the future if radiologists remain poorly understood and recognized by patients. My view is that this is simply not true. The reality is that the referring physician is our first and most important customer. Patients and hospitals are the two additional and also very important customers. As such, as long as we continue to provide tremendous value to our referring physicians and maintain good relationships with hospitals and health-care systems, we will prosper. It is simply not important that patients consistently encounter radiologists or get to know them.

Of course, patient satisfaction during visits to the radiology department is very important, but it does not hinge on a personal interaction between the radiologist and the patient (although this is occasionally necessary and useful). And let’s not forget that this is another activity that no one wants to pay for. The truth is that referring physicians would generally prefer that radiologists refrain from inserting themselves into the mix and tend to view [radiologists’] interactions with patients] as unnecessary interference.

Imaging 3.0 Work Group: Engaging patients in the decision-making surrounding their imaging care does not mean that radiologists need to develop a personal relationship with each patient. However, with the increasing focus on value-based and cost-effective care, it is incumbent on medical professionals to seek opportunities to increase value and decrease costs in novel ways. There is growing evidence (http://bit.ly/HealthOutcomes) that more engaged patients have better outcomes and lower costs.

Dr. Heisel raises an important point that some referring physicians may be uncomfortable with a direct interaction between their patients and a radiologist. However, we would point to the almost 20 years of federally mandated communication between patients receiving mammography services and the radiologists who provide those services. We believe that it has contributed to higher-quality care and has not been detrimental to the relationship patients have with their primary care or other physician.

Dr. Heisel: Yes, change is on the horizon, but the best approach is to stay the course and keep doing the things we do well. Radiology will succeed if it focuses on creating reports of the highest quality and accuracy and delivering them in a timely manner. Our services will become even more indispensable and essential as we continue to meet the demands for 24/7/365 real-time coverage of ED and inpatient exams. It really does not need to be so complicated. We need to stay true to proven business principles, like not giving our services away for free, not negotiating with the idea that we will inevitably lose ground, not accepting the idea that we are moving toward increased irrelevance, and not believing the assertions that so much of our imaging services can be categorized as unnecessary.

Imaging 3.0 Work Group: We can all agree with Dr. Heisel’s comment that we should be dedicated to quality. However, the payments for the high-quality care to which he alludes have already begun to decline and will likely not be regained. Dr. Heisel seems to prefer that fee-for-service remain in place with no reduction in reimbursement. But in reality, unless we want to work progressively harder, interpreting more cases for less reimbursement per case, radiologists need to be prepared to move beyond image interpretation. The Imaging 3.0 Work Group has evaluated many expert opinions about how the health-care system can provide the best value in patient care, and our recommendations represent our best assessment of what radiologists can do to increase the value proposition they provide.

Although medical imaging remains central to medical care, it is important not to confuse imaging with radiologists. In order for radiologists to remain central to medical care, we believe we need to exert our influence beyond just the interpretation of images. Through Imaging 3.0 radiologists will improve imaging care for all stakeholders — patients, referring physicians, and payers. Many of us would prefer to ignore the profound environmental changes that are upon us; however, doing so is not without risk.

There are many examples of individuals, companies, and organizations losing influence or even becoming extinct because they chose to stay the course in changing times. Rather than staying the course, Imaging 3.0 provides a proactive, integrated, and patient-centric approach to imaging care. If adopted by radiologists, referring physicians, patients, and payers, the Imaging 3.0 strategy provides a win-win situation for all relevant stakeholders. We urge our colleagues to look to the future — not to the past — and optimize opportunities to enhance value in all we do.


LETTER TO THE EDITOR <<<

GOT A COMMENT?
Send letters to the editor to bulletin@acr.org.
Patient Engagement Goes Online
YOU’VE LAUNCHED YOUR PATIENT PORTAL. NOW WHAT?
By Lyndsee Cordes

In June, the Bulletin interviewed radiologists about their experiences implementing online patient portals. (Read about it at http://bit.ly/Online-Portals.) But to satisfy meaningful use (MU) requirements, radiologists must do more than just launch a patient portal. For stage 2 of MU, patients must also use that portal to engage with their electronic health records (EHRs). The ACR summary of the guidelines states that in order for an eligible professional (EP) to achieve this objective, “more than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) [must] view, download, or transmit to a third party their health information.”1

While many practices already have a patient portal, Mike Peters, ACR director of regulatory and legislative affairs, notes, “The challenge is not so much implementing the patient portal itself, but getting enough patients to utilize its functionality to meet the associated meaningful use measures.” As stage 2 MU nears for those who began participating in 2011 or 2012, radiologists are taking a closer look at their portals and implementing strategies to increase patient engagement.

Alberto Goldszal, PhD, MBA, CIO at University Radiology in New Jersey, is overseeing his practice’s engagement efforts and encouraging patients to take advantage of the portal. The practice attested successfully for year 1 and 2 of MU stage 1. Like in many practices, large and small, University Radiology physicians have not yet attained usage levels high enough to meet the stage 2 requirements. Curtis P. Langlotz, MD, PhD, vice chair for informatics in the Department of Radiology at Penn Radiation, a part of the University of Pennsylvania Health System in Philadelphia, works on his institution’s system-wide patient portal, which includes radiology reports. While University of Pennsylvania Health System physicians successfully attested to stage 1 MU, many are now assessing their eligibility for stage 2. Both Goldszal and Langlotz point to a variety of challenges for radiologists hoping to meet the requirements.

One problem Goldszal sees is portal fatigue. As providers across the spectrum of care work to come on board with MU, patients are given access to portals for a variety of providers. And, says Goldszal, if the system works as intended, the radiology report could show up in both the radiology portal and the referring physician’s portal, removing the need for patients to access the radiology portal. While more portals lead to patient familiarity, this also means more passwords, more URLs, and more records for patients to keep track of. And that’s assuming all patients have the experience and online access necessary to tap into the portals in the first place. “In our area, there is wide variation in the degree of internet connectivity, smart phone usage, and technological savvy,” says Langlotz.

But for Langlotz, the main obstacle is patients’ standards when it comes to what they expect to be able to do online. “We need to provide more features that patients really want,” he says. “It’s nice to view your test results and request prescription refills online. But I think what we really need is scheduling. If you can purchase a plane ticket and select a seat online (saving both the customer and the airline lots of time on the phone), why

PROMOTE YOUR PORTAL

In order to respond to the challenges and increase patient engagement, practices are using the following strategies:

Do a pilot program. At University Radiology, Goldszal enlisted employees and their families who were also patients to try out the portal for three months. This allowed staff to see where patients were having trouble and work out any bugs.

Get the word out. University of Pennsylvania Health System did an initial marketing push that included a radio ad with the tag line, “Get your medical records like you get your music” (online). At University Radiology, patients can pick up printed postcards at the front desk. Staff also offers to help patients set up and tour their account on a tablet in the waiting room.

Show what’s in it for patients. Present your portal as a value-added service by emphasizing helpful features and keeping talk of meaningful use incentives to yourself. Patients will access the portal if they see a valid reason to do so, not because you want them to help you meet MU requirements.

Make a business case. “We’re focusing on our portal because we think it’s good business sense, not because of the requirement of meaningful use,” says Goldszal. For his practice, increasing patients’ involvement in their health and strengthening the physician-patient relationship are reasons to consider establishing a portal, independent of the stage 2 incentives.

(continued on page 29)
Making Connections

A UNIQUE COMMISSION BRINGS TOGETHER DIVERSE GROUPS WITH SIMILAR NEEDS.

The Commission on General, Small, and/or Rural Practice (GSR) is a specialty commission representing ACR members who are general radiologists, practice general radiology, are members of small groups, or practice in rural locales. Unlike the groups represented by other specialty commissions, GSR radiologists have no specialty societies focused on their unique needs. Although the exact number is unknown, the commission represents thousands of members that fit in one or more of these GSR categories. It is a challenge for them to meet, converse, and share concerns and problems in real time.

Historically, it has been very difficult for the leadership of the ACR to identify these members, to obtain feedback and insights about their issues, and to identify or cultivate future leaders out of these ranks. In an attempt to bridge this gap, the GSR Network Committee, chaired by Charles W. Bowkley III, MD, was formed with the mission to create a virtual society for GSR radiologists. The committee’s first success was establishing a GSR Network, which has now been operational for several months and has members from almost every state. This core group will serve as a vital resource for the leaders from the GSR Commission and other commissions in the College looking to obtain insight and advice on issues that affect our GSR members.

We have also created an online web portal, where we house resources for the network members and, most importantly, provide a discussion forum where they can more actively engage one another in real time. The next step is to develop a strategy for broader engagement of the GSR members through a variety of social media. The ultimate goal is to have a vibrant virtual society that can discuss and bring forward the issues of concern to our GSR members. This will create an opportunity for members to exchange ideas and come to know one another professionally and personally. The task is just beginning, and we are hopeful that the web portal will be up and running by sometime this fall. We’ve made a great start and the work continues.

The commission performs a variety of functions on behalf of the ACR members through its committees comprised of talented and dedicated volunteer radiologists. Below, I describe the various committees that fall under the GSR Commission. In addition to creating a web page on the ACR website for the commission, we have also created a web page for each of the committees. Each of these pages contains information on committee members, staff contacts, and resources pertaining to the committee. To take a look, visit http://bit.ly/GSRCommission.

GSR Committees

The Committee on Practice Guidelines and Technical Standards, chaired by Matthew S. Pollack, MD, FACR, manages the revision and development of guidelines related to general radiology, as well as the guidelines that deal with the overall practice of radiology.

The Committee on Economics is chaired by Robert S. Pyatt Jr., MD, FACR. The committee meets monthly to discuss a wide variety of economics issues and has produced several webinars on the major economic issues impacting the practice of radiology. The committee plans to continue these webinars and develop a library of resources for GSR radiologists.

As recommended by the Task Force on the General Radiologist in the 21st Century, in order to study and promote the concept of a multi-specialty radiologist (MSR), a committee was formed with Paul A. Larson, MD, FACR, as the chair. (Read more about the task force in its 2012 report at http://bit.ly/JACR21stCentury.) The committee has begun its work and recently published a bibliography of key literature on the various roles played by the general radiologist, the MSR, and single-specialty radiologists.

Emergency radiology is a growing subspecialty area. The newly formed Emergency Radiology (ER) Committee, chaired by Stephen F. Hatem, MD, is housed within the GSR Commission to provide the committee with administrative support and organizational presence. The committee provides the emergency radiologist’s perspective on all matters of interest throughout the College.

In addition to the committees within the GSR Commission, close coordination with the Commissions on Human Resources and Education is provided by E. Michael Donner III, MD, FACR, and Steven B. Birnbaum, MD, respectively. These are exciting times. The commission’s web page has been updated with new resources for practicing radiologists. The GSR Network promises to become a reliable source of information about what is occurring on the ground throughout the country. The creation of a virtual specialty society for GSR radiologists through the use of social media will open up new avenues of communications among our members. The GSR Commission will continue to represent the needs of general radiologists and small and rural practices through initiatives like these and many more. //
The NOPR Proves FDG PET’s Powerful Impact

AS THE FDG PET COMPONENT WINDS DOWN, THE RESEARCH TEAM LOOKS BACK ON SIGNIFICANT MILESTONES IN THE INITIATIVE’S HISTORY.

By Nancy Fredericks, MBA

The National Oncologic PET Registry (NOPR) closed accrual to its fluorodeoxyglucose (FDG) PET registry on June 12, 2013, after seven years of operation. During that time, clinical data collected from the vast majority of PET imaging facilities in the United States confirmed that FDG PET scans provide vital information for determining the best treatment options for patients with cancer.

The NOPR, among the first CMS-sponsored Coverage with Evidence Development (CED) initiatives, provided hundreds of thousands of Medicare beneficiaries with access to FDG PET scans that otherwise would not have been covered. The registry had broad support among professional medical societies and was sponsored by the Academy of Molecular Imaging and managed by the ACR through ACRIN®.

January 2005: CMS indicates its intent to establish a new CED mechanism that will provide coverage of promising technologies contingent upon the collection of clinical data to demonstrate the impact on health outcomes.

April 2005: CMS posts the draft guidance document “Coverage with Evidence Development: National Coverage Determinations Requiring Data Collection as a Condition of Coverage.” In response, a multidisciplinary team of investigators from an array of professional societies begins designing a program to collect clinical data about FDG PET’s effect on physician treatment plans for many cancer indications for FDG PET scans not eligible for Medicare reimbursement.

May 2005–April 2006: Project managers, computer programs, data managers, and others join the NOPR development team, working with CMS representatives to successfully navigate numerous operational, regulatory, technical, and scientific hurdles.

May 2006: The NOPR receives final approvals and goes into operation. The first electronic data are submitted to the registry’s database, documenting referring physicians’ care plans prior to and after an FDG PET scan.

October 2006: More than 1,300 PET facilities are signed up to participate in the NOPR. Data for over 12,500 patient scans have been successfully submitted.

April 2007: The NOPR investigators publish their first paper in the American Journal of Roentgenology, reporting on the registry’s purpose and methods.

May 2007: More than 35,000 FDG PET scans have been performed under the NOPR auspices, and nearly 1,500 PET facilities have signed on to participate.

November 2007: The NOPR’s design and analysis plan is published.

March 2008: The first NOPR results are published, demonstrating that physicians often change their intended patient treatment plans based upon FDG PET scan results across the full spectrum of indications.

The NOPR investigators formally request that CMS 1) reconsider its current National Coverage Decision (NCD) on FDG PET; 2) provide coverage for diagnosis, staging, and restaging for all cancers; and 3) end the data collection requirements for these indications. The investigators further request that the registry continue to collect data for FDG PET studies of treatment monitoring.

April 2008: CMS initiates a review of the NOPR investigators’ request and convenes a Medicare Evidence Development and Coverage Advisory Committee panel.

“Sufficient evidence was lacking that PET improved health outcomes. In the absence of Medicare coverage, researchers were unable to develop the clinical data necessary to demonstrate that broader coverage was warranted. CMS’ novel coverage with evidence development mechanisms allowed for the collection of data to prove FDG PET reasonable and necessary for the vast majority of cancer types and indications — the legal threshold for coverage under Medicare.”

— Barry A. Siegel, MD, FACR, NOPR co-chair
November 2008: Two more NOPR analyses are published. NOPR investigators report that results from FDG PET affect how clinicians manage their cancer patients’ care, regardless of the cancer type and reason for ordering the imaging scan. The NOPR data show physicians change the treatment plan for 43 percent of their patients undergoing cancer treatment as the result of FDG PET information.

January 2009: CMS releases its proposed FDG PET–coverage decision to significantly expand coverage for diagnosis and initial staging for patients with nearly all cancer types. The proposal allows for restaging, detection of suspected recurrence, and treatment monitoring for an expanded number of cancer types. However, certain FDG PET indications continue to be covered only under a revised NOPR program. To address the new CED requirements, NOPR investigators develop the NOPR-2009 successor registry.

April 2009: CMS announces the new NCD expanding FDG PET coverage based on the NOPR-generated evidence. The NOPR 2009 registry is launched.

November 2009: CMS expands coverage for the use of FDG PET for initial staging of cervical cancer and ends the data collection requirement for this indication.

February 2010: CMS announces the coverage of F-18 sodium fluoride (NaF-18) PET to identify bone metastasis only under an approved CED initiative. The NOPR investigators consider adapting the FDG PET registry to collect data about referring physicians’ treatment plans before and after an NaF-18 PET scan.

June 2010: The NOPR investigators announce their decision to implement a data registry for NaF-18 PET. Registry development begins.

February 2011: CMS publishes a final NCD pertaining to the coverage of NaF-18 PET. The registry begins collecting data.

May 2012: The NOPR investigators publish results comparing data from the FDG PET registry begun in 2006 with data from the revised NOPR 2009. The datasets show similar results of the impact of FDG PET on physicians’ planned treatment of their cancer patients.

July 2012: The NOPR investigators formally request that CMS expand coverage for the remaining oncologic FDG PET indications covered only through NOPR participation. They also request that CME end the CED requirement for coverage of oncologic FDG PET scans.

March 2013: CMS releases a proposed NCD memorandum expanding coverage for remaining NOPR-covered FDG PET indications. However, the use of oncologic FDG PET for subsequent patient management is restricted to a single lifetime scan per cancer, with additional scans to be covered at the discretion of local Medicare administrative contractors.

April 2013: NOPR investigators submit a comment letter agreeing with the CMS recommendation to close the FDG PET registry. The letter also provides evidence to show that the single-scan limit for subsequent patient management would not be in the best interests of Medicare beneficiaries.

June 2013: CMS issues a final decision memorandum calling for the end of the NOPR’s prospective data collection. The limit of one scan for subsequent FDG PET imaging is expanded to three. The NOPR 2009 registry ends data collection.

July 2013: The NaF-18 PET registry remains open, with over 860 participating PET facilities and data for more than 15,000 cases. Data analysis and manuscript development are well underway.

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“We are pleased that the NOPR experience has led to fruitful collaborations in the advanced imaging community and has also facilitated more CMS engagement with that community.”

— Louis B. Jacques, MD, director, CMS Coverage and Analysis Group
Another Challenge Lurks in the Affordable Care Act

**WHAT DO YOU NEED TO KNOW ABOUT STATE INSURANCE EXCHANGES?**

Time can fly, even when it comes to the law. Over three years have passed since President Obama signed the massive Patient Protection and Affordable Care Act, aka the health reform law. The ACR has educated members about key changes, such as the higher equipment utilization rate and new payment models. But just when you thought that the act could not pose more challenges, an unheralded provision has surfaced that could further complicate your practice.

The act created health insurance exchanges, or competitive marketplaces, to remedy continued market barriers for individuals seeking coverage. Each state may establish an exchange to allow individuals and small employers to shop for insurance based on price, quality, and other factors. The government will offer tax credits to encourage individuals and families to obtain insurance through the exchanges. Open enrollment will occur in October 2013, and the exchanges will take effect January 1, 2014. However, a little-known part of the act may shift payment risk to radiology and radiation oncology practices if insured patients do not pay their premiums because of financial hardship or other reasons. Some officials in organized medicine question whether this loophole will affect physicians' ability to sustain their practices. In this column, we will outline the insurance provision and how practices should address yet another challenge in health reform.

**What is the act’s controversial provision about state insurance exchanges?**

Under Section 1411 of the act, a qualified health plan that participates in the exchange and collects health insurance premiums from enrollees must allow a three-month grace period for paying premiums before the plan discontinues coverage. Patients who receive the subsidized coverage qualify for the grace period by paying at least one month's premium. However, the government decided in the exchange’s final rule to require insurers to pay medical claims only during the first month of the grace period. In the other two months, the exchange requests that they pay their medical bills or their insurance premium if they receive health care services. If the patients do not pay either bill, however, physicians have to cover the cost of care.

**Why do some health officials regard this provision as a loophole?**

Nonpayment of premiums could leave a practice responsible for an undefined amount of health-care costs, accumulated over the course of up to sixty days. This gap especially could affect radiation oncologists, interventional radiologists, and breast imagers because they frequently provide care to patients during a continuous period of time. Small or rural practices that treat underserved populations might experience difficulties if many patients do not pay on time.

**Did the government recognize that its policy might affect patient care delivery?**

Yes. HHS, which oversees the exchanges, acknowledged that pending claims “increase uncertainty for providers and increase the burden of uncompensated care.” HHS originally proposed that insurers pay all claims during the grace period. However, it changed its position because of concerns that a statutory three-month grace period policy — which is longer than most commercial insurance grace periods — might cause different premiums between the exchange and non-exchange markets. Additionally, individuals could face a tax liability for any advance payments of the premium tax credit that the government pays on their behalf in a month in which they did not pay their premium share. The government has attempted to alleviate the burden by requiring insurers to inform physicians of any delinquencies within 15 days after insurers no longer have to pay claims.

State exchange representatives agree that physicians will bear some risk. Yet they assert that federal subsidies should allow families to buy affordable insurance that will reduce the prospect of a three-month delinquency. Nonetheless, practices that treat patients covered by the exchanges would have a two-week time frame (between days 31 and 45 of the grace period) in which they could render care and not know that insurance reimbursement is uncertain.

**Can practices decide not to participate after signing an exchange contract with insurers?**

Not necessarily. You may have agreed to contract with a large health insurer, such as Anthem Blue Cross, that typically imposes an “all products clause.” That provision would obligate you to treat any patient that the health plan covers. The contract likely would impose a financial penalty if you terminated participation. You also must avoid inquiring about insurance status before providing care to a patient who presents to a hospital's emergency department and requests treatment, which the federal Emergency Medical Treatment and Active Labor Act prohibits.

**What will this mean for groups that consider joining the state insurance exchanges?**

Groups will, again, have to weigh the Affordable Care Act’s long reach. Plan early and prudently with your business administrator. Review exchange contracts thoroughly. Assess your potential patient mix and fiscal risk.

Visit the digital version of the Bulletin to view the endnotes for this article.
can’t you schedule your medical appointments the same way?”

Another, perhaps more fundamental, challenge is the fact that physicians cannot, and indeed should not, force patients to use a portal, no matter how many benefits it may provide. “All we can do is build the portal, train patients on how to use it, show the portal’s value to patients, and be open for business,” says Goldszal. “At the end of the day, it’s going to depend on the patient.”

ENDNOTE
You don’t need tables and facts to know that as you age, you tend to become less active. Careers, marriages, children, and community service can all take their toll, and eventually something has to go. For too many of us, what goes is time spent on keeping fit. For radiologists, this problem is compounded by a sedentary work environment. Most of us sit in front of a bank of computer terminals for nine hours a day without moving. It probably requires significant effort just to get up and walk to the candy machine in the ER.

I’m convinced that keeping fit requires daily, consistent work. Just like everything else in life, the greater the effort you exert, the better the results. Unfortunately, the most difficult part of fitness is getting fit, not staying fit. This is where most people decide it’s not worth the effort. Going from out of shape to in shape is painful, and results take weeks or months to feel.

If it’s been a while, you might want to begin with a physical to be sure everything is in working order. Start with 20 minutes a day over one month, then move up to an hour a day. Every day. Don’t excuse yourself because of the weather, daylight savings time, or lack of sleep the night before. You’ll never regret a workout you completed, but you will regret the one you cancelled.

These recommendations are not only supported by data but also come from my personal experience. I made a huge effort to get fit about 10 years ago, and I have stayed fit, just by working at it every day. Feeling fit is luxurious and wonderful, and no physician needs to be reminded of the health benefits of physical fitness. You spend your entire career taking care of others. Now it’s time to take care of yourself.

“You’ll never regret a workout you completed, but you will regret the one you cancelled.”

— Maryellyn Gilfeather, MD, FACR

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WHAT DO YOU DO TO AVOID HEALTH PROBLEMS ASSOCIATED WITH SITTING FOR HOURS EACH DAY?
Her daughters’ birthday wish is for her to be there for all the ones to come.

Urge your patients to start annual mammograms at 40

Every major American medical organization experienced in breast cancer care recommends that women start getting annual mammograms at age 40. Because one in six breast cancers occur in women in their 40s. And studies show that regular mammograms cut breast cancer deaths by approximately a third in all women 40 and over. Plus 75% of all women diagnosed with breast cancer had no family history or factors that put them at high risk. Encourage your patients to get annual mammograms as soon as they turn 40.

Patient information and accredited mammography centers can be found at mammographysaveslives.org

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Representatives from real-world facilities will examine how the ACR Data Registries are useful for quality benchmarking and provide in-depth case studies.

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